

**SPAIN**



**New law transforms mental health system in Spain**

In 1986 the General Public Health Law was passed which included a chapter on mental health. This law facilitated the transformation of psychiatric hospitals, deinstitutionalization, the mainstreaming of mental health and its development in primary care and community programmes. Mental health centres were developed for psychiatric ambulatory care, inpatient

units were opened in general hospitals and therapeutic communities were created for the treatment and rehabilitation of persons with the most serious mental disorders (Montejo & Espino, 1998).

After 10 years of implementation of this psychiatric reform, large changes have occurred in some of the autonomous communities, e.g. Andalucia, Asturias and Madrid. In these regions the number of beds in psychiatric hospitals decreased from about 100 to fewer than 25 per 100 000 inhabitants. After an average stay in hospital of 21 years, people were able to return to their families in 25% of the cases, while 50% of them were able to live in sheltered accommodation. Approximately 500 mental health centres have been opened with an average coverage of 87 000 people. Ninety-five inpatient psychiatric units in general hospitals and 108 day hospitals have been created. In several regions, social services have developed rehabilitation programmes, including social enterprises with paid jobs for persons with mental disabilities. Clinical training programmes for psychiatrists and psychologists have been set up, allowing a significant increase in the numbers of these professionals.

*Source: Mental health policy, plans and programme (updated version). Geneva, World Health Organization, 2005 (Mental Health Policy and Service Guidance Package)*



**CHILE**

**The National Commission takes active steps to protect the rights of people with mental disorders in Chile**

As part of the overall health sector reform in Chile, a new charter on the rights of patients has been introduced which has served to facilitate the implementation of measures to protect and promote the rights of people with mental disorders. A National Commission for the Protection of People with Mental Illness, with the participation of users and families, started work in March 2001. A process of education of mental health workers about the rights of people with mental disorders who are admitted to psychiatric facilities has been



started in the country with positive results. The common practice of psychosurgery for mental disorder associated with violent behaviour has effectively been stopped in the country, violations of human rights in some psychiatric facilities are being investigated, and people with mental disorder and their families have been able to present their difficulties regarding access to treatment and rehabilitation. As an example of the work of the Commission, prior to its establishment, every year psychosurgery was performed, on average, on 40 patients for severe mental disorder associated with aggressive behaviour. In the first two-and-a-half years after its establishment, the Commission was requested to assess only 11 candidates for psychosurgery and all were turned down, as other more appropriate interventions, with less risk to the patient, were available (*Personal communication, Dr A. Minoletti, Ministry of Health, Chile, 2002*)

**Source:** *WHO Resource book on mental health, human rights and legislation. Geneva, World Health Organization, 2005*



## **ITALY**

### **Mental health law reform mental health services and improves human rights in Italy**



Twenty years ago the Italian Parliament passed “Law 180” which aimed to bring about a radical change in psychiatric care throughout the country. The law comprised framework legislation (*legge quadro*), entrusting regions with the tasks of drafting and implementing detailed norms, methods, and timetables for the translation of the law’s general principles into specific action.

For the management of psychiatric illness, three alternatives to mental hospitals have been set up: psychiatric beds in general hospitals; residential, non-hospital facilities, with full-time or part-time staff; and non-residential, outpatient facilities, which include day hospitals, day centres, and outpatient clinics.<sup>1</sup>

In the first 10 years following approval of the law, the number of mental hospital residents dropped by 53%. The total number discharged over the past two decades is, however, not known precisely. Compulsory admissions, as a percentage of total psychiatric admissions, have steadily declined from about 50% in 1975 to about 20% in 1984 and 11.8% in 1994. The “revolving door” phenomenon – discharged patients who are readmitted – is evident only in areas that lack well-organized, effective, community-based services. Even in the context of the new services, recent surveys show that psychiatric patients are unlikely to receive optimum pharmacotherapy, and evidence-based psychosocial modes of treatment are unevenly distributed across mental health



## BEST PRACTICES -Mental health, human rights & legislation

services. For example, although psycho-educational intervention is widely regarded as essential in the care of patients suffering from schizophrenia, only 8% of families received some form of such treatment. The scant data available seem to show that families have informally taken on some of the care for the ill relative, which was previously a responsibility of the mental hospital. At least some of the advantages to patients appear to be attributable more to everyday family support than to the services provided. The following lessons may be drawn. First, the transition from a predominantly hospital-based service to a predominantly community-based service cannot be accomplished simply by closing the psychiatric institutions: appropriate alternative structures must be provided, as was the case in Italy. Second, political and administrative commitment is necessary if community care is to be effective. Investments have to be made in buildings, staff, training, and the provision of backup facilities. Third, monitoring and evaluation are important aspects of change: planning and evaluation should go hand in hand, and evaluation should, wherever possible, have an epidemiological basis. Last, a reform law should not only provide guidelines (as in Italy), but should be prescriptive: minimum standards need to be determined in terms of care, and in establishing reliable monitoring systems; compulsory timetables need to be set for implementing the envisaged facilities; and central mechanisms are required for the verification, control and comparison of the quality of services.<sup>1</sup>de Girolomo G, Cozza M (2000). The Italian psychiatric reform: a 20-year perspective. *International Journal of Law and Psychiatry*, 23(3–4): 197–214.

**Source:** Box 4.4: Mental health reform in Italy. Cited in *World health report 2001. Mental health: new Understanding, new hope*. Geneva: World Health Organization. Available From URL:<http://www.who.int/whr/2001/en/>



BEST PRACTICES - Mental health, human rights & Legislation

## GHANA

### Protecting rights through mental health legislation in Ghana

Ghana, in collaboration with WHO, has recently developed a new Mental Health Bill to replace its previous outdated 1972 law. This outdated law strongly emphasized institutional care to the detriment of providing mental health care in primary health care settings, contrary to both national and international policy directives.



Furthermore, procedures for involuntary admission in the 1972 law did not sufficiently protect people against unnecessary admission. Indeed, serious mistreatments of people with mental disorders - some have been involuntarily locked away in institutions for decades - have persisted under this legislation.



## BEST PRACTICES -Mental health, human rights & legislation

It is in this context that Ghana requested the support of WHO in order to draft and implement new mental health legislation to promote best practice in treatment and care and to protect the human rights of people with mental disorders.

Through a series of training workshops, broad consultations with key national stakeholders, and ongoing critical analyses and reviews of the different drafts of the new law using WHO materials and tools, Ghana has developed a comprehensive Mental Health Bill which protects the rights of people with mental disorders and promotes mental health care in the community in accordance with international human rights standards.

Specifically, the new Bill aims to:

- Improve access to in-patient and out-patient mental health care in the communities in which people live
- Regulate mental health practitioners in both the public and private sectors
- Combat discrimination and stigmatization and promote human rights
- Promote voluntary treatment and, if necessary, voluntary admission to mental health facilities.
- Introduce safeguards to protect against arbitrary and unjustified involuntary admission and treatment

WHO is helping Ghana to prepare for the implementation of the new legislation, and has provided guidance on the elaboration of a detailed action plan and regulations for putting the provisions of the law into effect.

Ghana's Mental Health Bill has gained the support of doctors, nurses and traditional healers and can serve as a model for other African countries wishing to develop progressive mental health laws that respect international human rights standards.

Source: *WHO Country Summary Series - Ghana: A very progressive mental health law, WHO, 2007*



## BEST PRACTICES - Mental health, human rights & Legislation

### SOUTH AFRICA

#### Mental Health Law Reform In South Africa.

Soon after democratic rule was established in South Africa 1994, a law reform process was initiated to remove all discriminatory legislation and ensure that all laws were in line with the new human rights constitution of the country and international human rights standards. One of the laws identified as being in urgent need of reform was the Mental Health Act of 1973.



## BEST PRACTICES -Mental health, human rights & legislation

This law embodied a custodial approach to mental disorder and had not only dismally failed to protect a range of human rights that people with mental disability are entitled to, but was itself responsible for certain abuses of human rights. A number of investigations had in fact found serious human rights violations in a range of psychiatric institutions.

The reform process started in 1998 with a notification to a range of key stakeholders (eg. user groups, service providers, professional organizations, NGOs) that the Minister of Health was embarking on mental health law reform. A “package” with relevant information was compiled and sent to the identified stakeholders. This included important WHO and UN documents (such as the MI Principles, Mental Health Care Law), laws from other countries, key articles that had been written in South Africa about mental health law, recommendations on mental health service changes from a Ministerial Committee on mental health, inputs received by the ministry from groups of human rights activists and a section on mental health from a “White paper” for the Transformation of the Health System in South Africa which summarized agreed upon mental health policy for the country. These stakeholders were requested to peruse these documents, draw on their own experiences and send detailed comments on what they would like to see included in new mental health legislation. A large number of comments and recommendations were received. From these comments and from an understanding of the objectives of the government for mental health reform, a first draft of the new proposed legislation was drafted. This draft was then sent to a much wider constituency and was made open for public comment. Individual meetings were held with stakeholders and joint meetings where people with different points of view could debate issues, were held. Provinces (there are nine in South Africa) also had hearings and provided inputs. In particular the limitations of certain provinces to implement “ideal” legislation due to resource constraints was provided. This led to sometimes innovative changes, for example the establishment of a category of a “mental health care practitioner” who could conduct mental health examinations with regard to assisted and involuntary admission. A legal drafter assisted with translating all the inputs into “legal language” - though a particular objective was to keep the language as user friendly as possible.

When the Bill was submitted to parliament, the portfolio committee on health advertised widely, including through the press, that it would be holding public hearings on the proposed new legislation. A number of constituents provided inputs at these hearings.

The Mental Health Care Act (Act 17 of 2002) was approved by Parliament in 2002. Regulations were then drawn up and the Act came into force in 2005. Extensive training has been required to ensure that all relevant constituencies are aware of the contents of the legislation and how to enact the provisions.

## **Mental Health Care Act (Act 17 of 2002) – Republic of South Africa**

The objects of the Act (Article 3) are to:

- Regulate mental health care in a manner that:
  - (1) makes the best possible mental health care, treatment and rehabilitation available to the population equitably, efficiently and in the best interests of mental health users within the limits of the available resources,
  - (2) co-ordinates access to mental health care, treatment and rehabilitation services to various categories of mental health care users, and
  - (3) integrates the provision of mental health care services into the general health services environment;
- Regulate access to and provide mental health care, treatment and rehabilitation to:
  - (1) Voluntary, assisted and involuntary mental health care users,
  - (2) State patients (mentally ill offenders),
  - (3) Mentally ill prisoners;
- Clarify the rights and obligations of mental health care users and the obligations of mental health care providers;
- Regulate the manner in which the property of persons with mental illness and persons with severe and profound intellectual disability may be dealt with by a court of law.

### **Provision of mental health care. treatment and rehabilitation**

The law outlines a system of health care that emphasizes the integration of mental health into general health care at primary and secondary levels. It also states that health services must promote the provision of community based care, treatment and rehabilitation services. In addition psychiatric hospitals (for people with mental illness) and care and rehabilitation centers (for people with severe and profound intellectual disability) are set up by the legislation to admit and care for particular categories of users such as assisted and involuntary users, mentally ill offenders, mentally ill prisoners and voluntary users into specialized programmes. The vast majority of care should take place at primary care level, followed by secondary and lastly tertiary services.

### **Rights and duties relating to mental health care users**

Various rights are outlined and explained. These include:

- 1) Respect, human dignity and privacy
- 2) Consent to care, treatment and rehabilitation services and admission to health establishments
- 3) Unfair discrimination
- 4) Exploitation and abuse
- 5) Determinations concerning mental health status
- 6) Disclosure of information

## BEST PRACTICES -Mental health, human rights & legislation

- 7) Limitations on intimate adult relationships
- 8) Right to representation
- 9) Discharge reports and
- 10) Knowledge of rights.

### **Mental Health Review Boards**

Mental health Review Boards are set up by the law to make decisions with regard to the admission and treatment of assisted and involuntary users. They must also hear appeals against decisions to admit and treat users without their informed consent and on a periodic basis consider all users who are deemed to require longer term care. They also consider applications for transfers to maximum security facilities and receive complaints of abuse or exploitation. Review Boards consist of at least one community member, one legal practitioner and one mental health care practitioner.

### **Voluntary, assisted and involuntary mental health care**

Voluntary care is encouraged. Criteria for when a person may be admitted as an assisted or involuntary user are outlined. Where a person refuses admission, in addition to being mentally ill to the extent that they lack capacity to make informed decisions the mental illness must be of such a nature that i)the user is likely to inflict serious harm to himself or herself or others ii)care, treatment and rehabilitation of the user is necessary for the protection of the financial interests or reputation of the user.

Processes for assisted and involuntary users are outlined. In both instances an application must be made and the user must be examined by two mental health care practitioners to determine whether they meet the criteria for admission. In the case of involuntary users they must initially also be admitted to a facility for a period of 72 hours where observation and a thorough assessment of the need for involuntary care is conducted. Involuntary care may be provided in either a mental health facility or in the community. A Review Board must then decide whether the assisted or involuntary admission is necessary. A judicial review must follow. Following admission all assisted and involuntary admissions must be reviewed on a periodic basis. Users may appeal against their admission and treatment. Any user who recovers to the point that they no longer meet the requirements for assisted or involuntary care may be discharged by the facility where they are admitted.

### **State patients (mentally ill offenders)**

While mentally ill offenders are admitted through the Criminal Procedure Act, they are discharged via the Mental Health care Act. Users may also receive “conditional discharges”.

### **Mentally ill prisoners**

If a prisoner becomes mentally ill to the extent that they need to be treated in a mental health facilities they can be transferred to such facility until they recover and can be returned to prison.

## BEST PRACTICES -Mental health, human rights & legislation

### Care and administration of property

Procedures for the high court to appoint a person to administer the property of a person with mental illness or intellectual disability is outlined.



BEST PRACTICES - Mental health, human rights & Legislation

### Suggested citation

*Best practices: Mental health, human rights and legislation.* Geneva, World Health Organization, 2007 ([http://www.who.int/mental\\_health/policy/legislation/en/index.html](http://www.who.int/mental_health/policy/legislation/en/index.html), accessed 7 August 2007; Best practices series, Sheet 3).

